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PROGRAM ATTACHMENT NO. 001
PURCHASE ORDER NO. 0000375889

CONTRACTOR: COLLIN COUNTY HEALTH CARE SERVICES

DSHS PROGRAM: Public Health Emergency Preparedness (PHEP)

TERM: 08/01/2011 THRU: 07/31/2012

SECTION I. STATEMENT OF WORK:

Contractor shall perform activities in support of the Public Health Emergency Preparedness Cooperative Agreement (Funding Opportunity Number CDC-RFA-TP11-1101) from the Centers for Disease Control and Prevention (CDC). CDC's new five-year Public Health Emergency Preparedness (PHEP) Cooperative Agreement seeks to advance public health preparedness by:

A. Establishing a prioritized and consistent set of public health preparedness capabilities;
B. Encouraging Contractor to measure abilities to achieve the public health preparedness capabilities and report how PHEP funds are used to achieve these capabilities;
C. Addressing lessons learned during the H1N1 influenza pandemic regarding the administrative preparedness necessary at the state and local levels for effective response as well as provide an improved mechanism for awarding response funding;
D. Accelerating public health emergency response funding by including a second funding authority provision for contingent emergency response funding;
E. Funding a limited number of higher population metropolitan statistical areas to develop all-hazards public health reduction strategies; and
F. Quantifying the return on investment of public funds for preparedness.

Contractor shall address the following CDC PHEP Capabilities by prioritizing the order of the fifteen (15) public health preparedness capabilities in which the Contractor intends to invest based upon:

A. A jurisdictional risk assessment;
B. An assessment of current capabilities and gaps using CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning; and*
C. CDC's recommended tiered strategy for capabilities as listed below in order of importance according to the CDC (not numerical order). Each capability is also defined further below.

Tier 1 Capabilities

Capability 12: Public Health Laboratory Testing

Capability 13:	Public Health Surveillance and Epidemiological Investigations
Capability 1:	Community Preparedness
Capability 8:	Medical Countermeasure Dispensing
Capability 9:	Medical Material Management and Distribution
Capability 14:	Responder Safety and Health
Capability 3:	Emergency Operations Coordination
Capability 4:	Emergency Public Information and Warning
Capability 6:	Information Sharing

Tier 2 Capabilities

Capability 11:	Non-Pharmaceutical Intervention
Capability 10:	Medical Surge
Capability 15:	Volunteer Management
Capability 2:	Community Recovery
Capability 5:	Fatality Management
Capability 7:	Mass Care

Capability 1 – Community Preparedness:

Definition: Community Preparedness is the ability of communities to prepare for, withstand, and recover – in both the short and long terms – from public health incidents**.**

Capability 2 – Community Recovery:

Definition: Community Recovery is the ability to collaborate with community partners, e.g., healthcare organizations, business, education, and emergency management) to plan and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels and improved levels where possible.

Capability 3 – Emergency Operations Center Coordination:

Definition: Emergency Operations coordination is the ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices with the National Incident Management System.

Capability 4 – Emergency Public Information and Warning:

Definition: Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management responders.

Capability 5 – Fatality Management:

Definition: Fatality management is the ability to coordinate with other organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death, and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident.

Capability 6 – Information Sharing:

Definition: Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to federal, state, local, territorial, and tribal levels of government and the private sector in preparation for and in response to events or incidents of public health significance.

Capability 7 – Mass Care:

Definition: Mass Care is the ability to coordinate with partner agencies to address the public health, medical, and mental/behavioral health needs of those impacted by an incident at a congregate location. This capability includes the coordination of ongoing surveillance and assessment to ensure that local health needs to continue to me met as the incident evolves.

Capability 8 – Medical Countermeasure Dispensing:

Definition: Medical countermeasure dispensing is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

Capability 9 – Medical Material Management and Distribution:

Definition: Medical material management and distribution is the ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport distribute, and track medical material (e.g., pharmaceuticals, gloves, masks, and ventilators) during an incident and to recover and account for unused medical material, as necessary, after an incident.

Capability 10 – Medical Surge:

Definition: Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

Capability 11 – Non-Pharmaceutical Interventions:

Definition: Non-pharmaceutical interventions are the ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control. Strategies include the following: isolation and quarantine; restrictions on movement and travel advisory/warnings; social distancing; external decontamination; hygiene; and precautionary behaviors.

Capability 12 – Public Health Laboratory Testing:

Definition: Public health laboratory testing is the ability to conduct rapid and conventional detection, characterization, confirmatory testing, data reporting, investigative support, and laboratory networking to address actual or potential exposure to all-hazards. Hazards include chemical, radiological, and biological, and biological agents in multiple matrices that may include clinical samples, food, and environmental samples (e.g., water, air, and soil). This capability supports routine surveillance, including pre-event incident and post-exposure activities.

Capability 13 – Public Health Surveillance and Epidemiological Investigations:

Definition: Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

Capability 14 – Responder Safety and Health:

Definition: The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

Capability 15 – Volunteer Management:

Definition: Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance.

DSHS encourages partnership and collaboration within, between, and among jurisdictions in the State of Texas related to preparedness activities. Partnership opportunities may include, but are not limited to, planning activities, exercises, training, and responding to incidents, events, or emergencies.

Contractor shall comply with all applicable federal and state laws, rules, and regulations including, but not limited to, the following:

- Public Law 107-188, Public Health Security and Bioterrorism Preparedness and Response Act of 2002;

- Public Law 109-417, Pandemic and All Hazards Preparedness Act of 2006; and
- Chapter 81, Texas Health and Safety Code.

Contractor shall comply with all applicable regulations, standards and guidelines in effect on the beginning date of this Program Attachment. This is an inter-local agreement under Chapter 791 of the Government Code.

Through this Program Attachment DSHS and Contractor are furnishing a service related to homeland security and under the authority of Texas Government Code § 421.062, neither agency is responsible for any civil liability that may arise from furnishing any service under this Program Attachment.

The following documents and resources are incorporated by reference and made a part of this Program Attachment:

- Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Public Health Emergency Preparedness Cooperative Agreement, Funding Opportunity Number: CDC-RFA-TP11-1101: http://www.grants.gov/search/search.do;jsessionid=7JnBNtWJ9LQLVKh8hD5PjQLLP5kldCdN5k2yVcpQZG7L80dL7pVf!-241849593?oppId=88673&mode=VIEW;
- *Public Health Preparedness Capabilities: National Standards for State and Local Planning, March 2011:* http://www.cdc.gov/phpr/capabilities/Capabilities_March_2011.pdf;
- Presidential Policy Directive 8/PPD-8, March 30, 2011: http://www.hlswatch.com/wp-content/uploads/2011/04/PPD-8-Preparedness.pdf;
- Hazard Risk Assessment Instrument from the University of California, Los Angeles Center for Public Health and Disasters: http://www.cphd.ucla.edu/npdfs/HRAI_Workbook.pdf;
- Project Period Public Health Emergency Preparedness Work Plan for Local Health Departments (Aug. 2011 through July 2012), attached as Exhibit A;
- Contractor's FY12 Applicant Information and Budget Detail for FY12 base cooperative agreement;
- Texas Public Health and Medical Emergency Management 5-Year Strategic Plan;
- Tactical Guide, Companion Document to the Texas Public Health and Medical Emergency Management 5-Year Strategic Plan 2012 to 2016;
- Homeland Security Exercise and Evaluation Plan (HSEEP) Documents: https://hseep.dhs.gov/pages/1001_HSEEP7.aspx;
- Ready or Not? Have a Plan; Surviving Disaster: How Texans Prepare (videos): http://www.texasprepares.org/survivingdisaster.htm; and
- Preparedness Program Guidance(s) as provided by DSHS and CDC.

The CDC PHEP Budget Period 11 (Aug. 2011 through July 2012) funds awarded herewith must be matched by costs or third party contributions that are not paid by the Federal Government under another award, except where authorized by Federal statute to be used for cost sharing or matching. The non-federal contributions (match) may be provided directly or through donations from public or private entities and may be in cash or in-kind donations, fairly evaluated,

including plant, equipment, or services. The costs that the Contractor incurs in fulfilling the matching or cost-sharing requirement are subject to the same requirements, including the cost principles, that are applicable to the use of Federal funds, including prior approval requirements and other rules for allowable costs as described in 45 CFR 74.23 and 45 CFR 92.24.

The Contractor is required to provide matching funds for PHEP Budget Period 11 (Aug. 2011 through July 2012) of the Funding Opportunity Number CDC-RFA-TP11-1101 not less than 10% of total costs. Refer to the DSHS Contractor's Financial Procedures Manual, Chapter 9 (http://www.dshs.state.tx.us/contracts/cfpm.shtm) for additional guidance on match requirements, including descriptions of acceptable match resources. Documentation of match, including methods and sources, must be included in the Contractor's contract budget, and Contractor must follow procedures for generally accepted accounting practices as well as meet audit requirements.

Contractor shall coordinate activities and response plans within the jurisdiction, with state, regional, other local jurisdictions, and tribal entities (where appropriate), with local agencies, with hospitals and major health care entities, jurisdictional Metropolitan Medical Response Systems, and Councils of Government.

If Contractor agrees to perform public health preparedness services for another county in exchange for all or a portion of the other county's funding allocation, Contractor shall submit to DSHS a signed Memorandum of Agreement (MOA) between Contractor and the other county. The MOA shall outline services, timelines, deliverables and the amount of funds agreed upon by both parties.

Contractor shall notify DSHS in advance of Contractor's plans to participate in or conduct local exercises, in a format specified by DSHS. Contractor shall participate in statewide exercises planned by DSHS as needed to assess the capacity of Contractor to respond to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. Contractor shall prepare and submit to DSHS After-Action Reports (AARs), documenting and correcting any identified gaps or weaknesses in preparedness plans identified during exercises in a format specified by DSHS and in compliance with Homeland Security Exercise and Evaluation Plan (HSEEP) standards.

Contractor shall cooperate with DSHS to coordinate all planning, training and exercises performed under this Program Attachment with the State of Texas, Governor's Division of Emergency Management of the State of Texas, or other points of contact at the discretion of the division, to ensure consistency and coordination of requirements at the local level and eliminate duplication of effort between the various domestic preparedness funding sources in the state.

Contractor shall participate in the Texas Disease Reporting Program described in Chapter 81, Texas Health and Safety Code by:

A. Educating, training and providing technical assistance to local providers and hospitals on Texas reportable disease requirements;

B. Monitoring participation by local providers and hospitals in appropriately reporting notifiable conditions;
C. Conducting disease surveillance and reporting notifiable conditions to the appropriate DSHS regional office;
D. Coordinating with DSHS regional Epidemiology Response Team members to build an effective statewide system for rapid detection of unusual outbreaks of illness through notifiable disease and syndromic or other enhanced surveillance; and
E. Reporting immediately all illnesses resulting from bioterrorism, chemical emergencies, radiological emergencies, or other unusual events and data aberrations as compared to background surveillance data to the jurisdiction's respective DSHS Health Service Region (HSR) regional office or to DSHS.

Contractor shall coordinate all risk communication activities with the DSHS Communications Unit by using DSHS's core messages posted on DSHS's website, and submitting copies of draft risk communication materials to DSHS for coordination prior to dissemination.

In the event of a public health emergency involving a portion of the state, Contractor shall mobilize and dispatch staff or equipment purchased with funds from the previous PHEP cooperative agreement and that are not performing critical duties in the jurisdiction served to the affected area of the state upon receipt of a written request from DSHS.

Contractor shall inform DSHS in writing if Contractor shall not continue performance under this Program Attachment within thirty (30) days of receipt of an amended standard(s) or guideline(s). DSHS may terminate the Program Attachment immediately or within a reasonable period of time as determined by DSHS.

Contractor shall develop, implement, and maintain a timekeeping system for accurately documenting staff time and salary expenditures for all staff funded through this Program Attachment, including partial FTEs and temporary staff.

DSHS reserves the right, where allowed by legal authority, to redirect funds in the event of financial shortfalls. DSHS will monitor Contractor's expenditures on a quarterly basis. If expenditures are below that projected in Contractor's total Contract amount, Contractor's budget may be subject to a decrease for the remainder of the Contract term. Vacant positions existing after ninety (90) days may result in a decrease in funds.

SECTION II. PERFORMANCE MEASURES:

Contractor must complete performance measures and benchmarks as outlined in the attached Exhibit A, Public Health Emergency Preparedness Work Plan for Local Health Departments Budget Period 11 (August 2011 to July 2012), and as noted below:

A. Demonstrated capability to rapidly assemble public health staff with lead incident management roles;
B. Demonstrated adherence to PHEP reporting deadlines;

C. Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency; and
D. Submit H1N1 After-Action Report Improvement Plan Status Reports.

Failure to meet these performance measures may result in withholding a portion of the fiscal year 2012 PHEP base award.

Contractor shall document the following Evidence-based Benchmarks and Objective Standards and Pandemic Influenza Plans:

A. Demonstrated capability to rapidly assemble public health staff with lead incident management roles.

1. To meet this benchmark, Contractors must demonstrate the capability for pre-identified staff covering activated public health agency incident management lead roles (or equivalent lead roles) to report for duty within 60 minutes or less. Staff assembly must be unannounced. To ensure a timely and effective response to an incident, Contractors must demonstrate the capability to immediately assemble public health staff with lead incident management roles. In recognition that an effective response will not occur if the necessary staff are not available, the ability to assemble lead incident management staff to initiate response actions in a timely manner has been deemed a top priority for CDC and the U.S. Department of Health and Human Services (HHS), and has been identified as an HHS Priority Goal for the fifty (50) states.

B. Demonstrated adherence to PHEP reporting deadlines.

1. PHEP mid-year progress report, due to DSHS on or before January 27, 2012, including a status update on work plan activities, Pandemic and All-Hazards Preparedness Act (PAHPA) benchmarks, performance measurement and demonstration plan activities, a five-year timeline for addressing the public health preparedness capabilities, and risk-based funding activities (if applicable).

2. End-of-year progress report, due to DSHS on or before August 15, 2012, including an update on work plan activities, risk-based funding activities (if applicable), a budget expenditure report, performance measurement, and demonstration plan activities.

C. Demonstrated capability to receive, stage, store, distribute, and dispense material during a public health emergency.

1. As part of their responses to public health emergencies, Contractor must be able to provide countermeasures to 100% of their identified population within 48 hours after the decision to do so. To achieve this standard, Contractor must maintain the capability to plan and execute the receipt, staging,

storage, distribution, and dispensing of material during a public health emergency.

2. Building on the framework and tools already established to assess capabilities to receive, distribute and dispense medical countermeasures, CDC has developed a composite measure to more fully represent preparedness activities and the collective gains of each of the sixty-two (62) PHEP-funded jurisdictions.

3. The medical countermeasure distribution and dispensing (MCMDD) composite score will serve as a collective indicator of preparedness and operational capability within local/planning jurisdictions, Cities Readiness Initiative (CRI) areas, states, directly funded cities, territories, and freely associated states. CDC will continue to conduct annual technical assistance reviews (TARs) of all sixty-two (62) PHEP awardees. Local, city, state, and territorial preparedness will be subsequently defined as a composite measure derived from results of TARs, drill submissions, full-scale exercise, and compliance with programmatic standards.

4. Using the individual composite scores to represent local jurisdiction preparedness, CDC will compute an overall MCMDD composite score for each of the sixty-two (62) jurisdictions. During the progression of the 2011-2016 PHEP cooperative agreement cycles, jurisdictions will be required to perform and/or submit documentation for a series of composite requirements to meet the advancing MCMDD composite benchmark. With the exception of the annual TAR and drill submission requirements, jurisdictions will have substantial flexibility in determining the order in which they perform or demonstrate capability to meet the composite measure. CDC will provide additional details and guidance on the MCMDD composite measure requirements at a subsequent date.

D. Submit H1N1 After-Action Report Improvement Plan Status Reports.

1. Contractors shall submit H1N1 AAR Improvement Plan Status Reports to DSHS by October 31, 2011 in a format to be determined by DSHS. Submission of the H1N1 After-action Report (AAR) Improvement Plan Status Report for 2011 is intended to provide summary status updates of the key improvement plan items from H1N1 AAR and Improvement Plans following the 2009-2010 H1N1 influenza pandemic response. Submission of these reports fulfills the pandemic influenza plan submission requirement.

Contractor shall provide services in the following county(ies)/area: Collin

SECTION III. SOLICITATION DOCUMENT:

Exempt - Governmental Entity

SECTION IV. RENEWALS:

DSHS may renew the Program Attachment for up to four (4) additional one-year terms at DSHS's sole discretion.

SECTION V. PAYMENT METHOD:

Cost Reimbursement.

Funding is further detailed in the attached Categorical Budget and, if applicable, Equipment List.

SECTION VI. BILLING INSTRUCTIONS:

Contractor shall request payment using the State of Texas Purchase Voucher (Form B-13) on a monthly basis and acceptable supporting documentation for reimbursement of the required services/deliverables. Additionally, the Contractor shall submit the Match/Reimbursement Certification (Form B-13A) and the Financial Status Report (FSR-269A) on a quarterly basis. Vouchers and supporting documentation should be mailed or submitted by fax or electronic mail to the addresses/number below.

Claims Processing Unit, MC1940
Texas Department of State Health Services
1100 West 49th Street
PO Box 149347
Austin, TX 78714-9347

The fax number for submitting State of Texas Purchase Voucher (Form B-13), Match/Reimbursement Certification Form (Form B-13A), and Financial Status Report to the Claims Processing Unit is (512) 458-7442. The email address is invoices@dshs.state.tx.us.

The email address for submitting mid- and end-of-year reports, plus any additional programmatic reports is PHEP@dshs.state.tx.us.

SECTION VII. BUDGET:

SOURCE OF FUNDS: *CFDA* # 93.069

SECTION VIII. SPECIAL PROVISIONS:

General Provisions, **Compliance and Reporting** Article, is revised to include:

> Contractor shall submit programmatic reports as directed by DSHS in a format specified by DSHS. Contractor shall provide DSHS other reports, including financial reports, and any other reports that DSHS determines necessary to accomplish the objectives of this contract and to monitor compliance. If Contractor is legally prohibited from providing such reports, Contractor shall immediately notify DSHS in writing.

Contractor shall provide reports as requested by DSHS to satisfy information-sharing Requirements set forth in Texas Government Code, Sections 421.071 and 421.072 (b) and (c).

General Provisions, **Terms and Conditions of Payment** Article, is revised to include:

DSHS will monitor Contractor's billing activity and expenditure reporting on a quarterly basis. Based on these reviews, DSHS may reallocate funding between contracts to maximize use of available funding.

General Provisions, **Allowable Costs and Audit Requirements** Article, is amended to include the following:

For the purposes of this Program Attachment, funds may not be used for: research; reimbursement of pre-award costs; clinical care; the purchase of vehicles of any kind, new construction, or the purchase of incentive items.

General Provisions, **General Terms** Article, **Amendment** Section, is amended to include the following:

Contractor must submit all amendment and revision requests in writing to the Division Contract Management Unit at least 90 days prior to the end of the term of this Program Attachment.

General Provisions**, General Terms** Article**, Contractor's Request for Revision of Certain Contract Provisions** Section, subsection a) is revised to read as follows:

a) provided that the total budget amount is unchanged: (1) cumulative budget transfers among direct cost categories, other than equipment, that exceed 10% of Program Attachments <u>of $100,000 or more</u>, and (2) cumulative transfers from or to the equipment category under 10% of any Program Attachment (cumulative transfers from or to the equipment category that equal or exceed 10% of any Program Attachment require an amendment to this Contract);

General Provisions, **General Terms** Article, **Contractor's Request for Revision of Certain Contract Provisions** Section, subsection e) is revised to read as follows:

e) changes in the equipment category of a previously approved equipment budget;